

Figure SC810.F9. Form CA-2, "Notice of Occupational Disease and Claim for Compensation"
- Sample Carpel Tunnel

Notice of Occupational Disease
and Claim for Compensation

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs



Employee: Please complete all boxes 1 - 18 below. Do not complete shaded areas.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

Employee Data			
1. Name of employee (Last, First, Middle) DAVIS, Mary J.			2. Social Security Number 002-22-0000
3. Date of birth Mo. Day Yr. 4 25 52	4. Sex F	5. Home telephone (703) 888-9696	6. Grade as of date of last exposure Level 7 Step 7
7. Employee's home mailing address (include city, state, and ZIP code) 1234 Jefferson Street, Apt A-3 Arlington, VA 22202			8. Dependents <input checked="" type="checkbox"/> Wife, Husband <input type="checkbox"/> Children under 18 <input type="checkbox"/> Other
Claim Information			
9. Employee's occupation Computer Specialist			a. Occupation code
10. Location (address) where you worked when disease or illness occurred (include city, state, and ZIP code) Pentagon, Washington, DC 22202-1155			11. Date you first became aware of disease or illness Mo. Day Yr. 12 1 93
12. Date you first realized the disease or illness was caused or aggravated by your employment Mo. Day Yr. 12 1 94		13. Explain the relationship to your employment, and why you came to this realization My work requires approximately 5-6 hours of intermittent keyboarding per day and I've had this job for the past 5 years. I first noticed tingling and numbness of my hands in December 1993. I saw a doctor on 2-15-94 who diagnosed carpal tunnel syndrome.	
14. Nature of disease or illness Carpal Tunnel Syndrome			OWCP Use - NOI Code b. Type code c. Source
15. If this notice and claim was not filed with the employing agency within 30 days after date shown above in Item #12, explain the reason for delay. N/A			
16. If the statement requested in item 1 of the attached instructions is not submitted with this form, explain reason for delay. N/A - Statement Attached			
17. If the medical reports requested in item 2 of attached instructions are not submitted with this form, explain reason for delay. N/A - Medical Attached			
Employee Signature			
18. I certify, under penalty of law, that the disease or illness described above was the result of my employment with the United States Government, and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and other benefits provided by the Federal Employees' Compensation Act. I hereby authorize any physician or hospital (or any other person, institution, corporation, or government agency) to furnish any desired information to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative). This authorization also permits any official representative of the Office to examine and to copy any records concerning me. Signature of employee or person acting on his/her behalf <u>Mary J. Davis.</u> Date <u>2-15-94</u> Have your supervisor complete the receipt attached to this form and return it to you for your records. Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.			

Form CA
Rev. Sep

Official Supervisor's Report of Occupational Disease: Please complete information requested below

Supervisor's Report	
19. Agency name and address of reporting office (include city, state, and ZIP Code)	
Department of the Army	OWCP Agency Code
Personnel and Security	OSHA Site Code
Room 3B347-Pentagon, Washington, DC 20301-1155	
ZIP Code	
20. Employee's duty station (Street address and ZIP Code)	
Pentagon	ZIP Code
21. Regular work hours	
From 0700 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.	To 0330 <input type="checkbox"/> a.m. <input checked="" type="checkbox"/> p.m.
22. Regular work schedule	
<input type="checkbox"/> Sun. <input checked="" type="checkbox"/> Mon. <input checked="" type="checkbox"/> Tues. <input checked="" type="checkbox"/> Wed. <input checked="" type="checkbox"/> Thurs. <input checked="" type="checkbox"/> Fri. <input type="checkbox"/> Sat.	
23. Name and address of physician first providing medical care (include city, state, ZIP code)	
Jack O. Smith, M.D.	
200 Duke Street	
Alexandria, VA 22302	
24. First date medical care received	
Day Yr. 02 15 94	
25. Do medical reports show employee is disabled for work?	
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
26. Date employee first reported condition to supervisor	
Mo. Day Yr. 12 01 93	
27. Date and hour employee stopped work	
Mo. Day Yr. 02 15 94 Time 0700 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
28. Date and hour employee's pay stopped	
Mo. Day Yr. 03 08 94 Time 0700 <input checked="" type="checkbox"/> a.m. <input type="checkbox"/> p.m.	
29. Date employee was last exposed to conditions alleged to have caused disease or illness	
Mo. Day Yr. 02 15 94	
30. Date returned to work	
Mo. Day Yr. <input type="checkbox"/> a.m. <input type="checkbox"/> p.m. Has Not Returned	
31. If employee has returned to work and work assignment has changed, describe new duties	

32. Employee's Retirement Coverage ☐ CSRS ☒ FERS ☐ Other, (Specify)

33. Was injury caused by third party?	34. Name and address of third party (include city, state, and ZIP code)
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
If "No," go to Item 34.	

Signature of Supervisor

35. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect to this Claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Carol R. James
Name of Supervisor (Type or print)

Carol R. James
Signature of Supervisor

Chief, Information Systems
Supervisor's Title

Date
(703) 695-0000
Office phone